REFERENCE No. 823.1

CONFIDENTIAL REPORT -NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

NO	CONFIDENTIA OT SUBJECT TO PI		IRE		
REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE				DATE COMPLETED	
TO BE COMPLETED BY REPORTING PA	ARTY. PLEASE PRINT OF	R TYPE. SEE GENERAL	INSTRUCTI	ONS.	
	nsents to disclosure of ir				
NAME (LAST NAME, FIRST NAME)			AGE	DATE OF BIRTH	
SSN GENDER ETHNICIT	TY	LANGUAGE (v" CHECK ONE) NON-VERBAL	ENGLISH	OTHER (SPECIFY)	
ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMB	UDSMAN)	CITY	ZIF	CODE TELEPHONE ()	
PRESENT LOCATION (IF DIFFERENT FROM ABOVE)		CITY	ZIF	CODE TELEPHONE ()	
()	OPMENTALLY DISABLED WN/OTHER	MENTALLY ILL/DI	SABLED	LIVES ALONE LIVES WITH OTHERS	
B. SUSPECTED ABUSER v" Check if NAME OF SUSPECTED ABUSER	Self-Neglect				
ADDRESS		CITY	ZII	P CODE TELEPHONE ()	
CARE CUSTODIAN (type) HEALTH PRACTITIONER (type)	PARENT SPOUSE	SON/DAUGHT OTHER RELA		HER	
GENDER ETHNICITY AG	E D.O.B.	HEIGHT WEIGHT	EYES	HAIR	
C. REPORTING PARTY Check appropriate	box if reporting party waives co	onfidentiality to: v" All	v" All but victi	m v" All but perpetrator	
NAME	SIGNATURE		OCCUPATION	AGENCY/NAME OF BUSINESS	
RELATION TO VICTIM/HOW ABUSE IS KNOWN	STREET	CITY	ZII	P CODE TELEPHONE	
E-MAIL ADDRESS				/	
D. INCIDENT INFORMATION - Address v	where incident occurred				
DATE/TIME OF INCIDENT(S)	PLACE OF INCIDENT (v° OWN HOME CON HOME OF ANOTHER	CHECK ONE) MMUNITY CARE FACILITY NURSING FACILITY/SW		TAL/ACUTE CARE HOSPITAL OTHER (Specify)	
E. REPORTED TYPES OF ABUSE (v"	CHECK ALLTHAT APPLY	Y)			
PERPETRATED BY OTHERS (WIC 15 PHYSICAL (e.g. assault/battery, conschemical restraint, over/under medical NEGLECT (including Deprivation of Gara Care Custodian	straint ordeprivation, ition) Goods and Services by	b. SEXUAL e. ABANDONMENT g. ABDUCTION i. OTHER	f. IS	INANCIAL SOLATION SYCHOLOGICAL/MENTAL	
2. SELF-NEGLECT (WIC 15610.57(b)(5))					
 a. PHYSICAL CARE (e.g. personal hygiene, food, clothing, shelter) b. MEDICAL CARE (e.g. physical and mental health needs) c. HEALTH and SAFETY HAZARDS (e.g. risk of suicide, unsafe environment) 		 d. MALNUTRITION/DEHYDRATION e. FINANCIAL SELF-NEGLECT (e.g. inability to manage one's own personal finances) f. OTHER 			
				ER REQUIRED	

A. VICTIM Check box if victim cor	nformation (Ombuds	AGE	- WIC 15636(a)) DATE OF BIRTH	
SSN GENDER ETHNICI	ΓΥ	LANGUAGE (v" CHECK ONE	<u> </u>	
M F		NON-VERBAL	ENGLISH	OTHER (SPECIFY)
ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMB	UDSMAN)	CIT	Y ZI	P CODE TELEPHONE
	,			()
PRESENT LOCATION (IF DIFFERENT FROM ABOVE)		CIT	Y ZII	P CODE TELEPHONE
				()
ELDEDLY (CE.)		NACNITA I I X/II I	/DICADI ED	LIVES ALONE
ELDERLY (65+) DEVELOPMENTALLY DISABLED PHYSICALLY DISABLED UNKNOWN/OTHER		MENTALLY ILI	T/DISABLED	LIVES WITH OTHERS
				LIVES WITH OTHERS
B. SUSPECTED ABUSER v" Check if	Self-Neglect			
ANIE OF GOOD ECTED ADOCEN				
ADDRESS		CIT	y ZI	P CODE TELEPHONE
				()
CARE CUSTODIAN (type)	PARENT	SON/DAU	GHTER OT	HER
HEALTH PRACTITIONER (type)	SPOUSE	OTHER RE	LATION	
GENDER ETHNICITY AG	E D.O.B.	HEIGHT WE	IGHT EYES	HAIR
M F				
. REPORTING PARTY Check appropriate	box if reporting party waives o	confidentiality to: v" All	v" All but vict	im v" All but perpetrator
AME	SIGNATURE	•	OCCUPATION	AGENCY/NAME OF BUSIN
RELATION TO VICTIM/HOW ABUSE IS KNOWN	STREET	CIT	Y ZI	P CODE TELEPHONE
				()
E-MAIL ADDRESS				
INCIDENT INFORMATION				
D. INCIDENT INFORMATION - Address N DATE/TIME OF INCIDENT(S)	1	"		
ATE/TIME OF INCIDENT(3)	PLACE OF INCIDENT (v	,		/- O. ITE O. DE . I OODIT. I
		MMUNITY CARE FACIL		TAL/ACUTE CARE HOSPITAL
	HOME OF ANOTHER	NURSING FACILITY/	SWING BED C	OTHER (Specify)
E. REPORTED TYPES OF ABUSE (v"	CHECK ALLTHAT APPL	.Y)		
I. PERPETRATED BY OTHERS (WIC 15	5610.07 & 15610.63)			
a. PHYSICAL (e.g. assault/battery, cons	,	b. SEXUAL	c. F	INANCIAL
chemical restraint, over/under medica	ation)	e. ABANDONMEN	T f. 19	SOLATION
d. NEGLECT (including Deprivation of C	Goods and Services by	g. ABDUCTION	h. P	SYCHOLOGICAL/MENTAL
a Care Custodian		i. OTHER		
2. SELF-NEGLECT (WIC 15610.57(b)(5))				
a. PHYSICAL CARE (e.g. personal hygi		d. MALNU	TRITION/DEHYDI	RATION
b. MEDICAL CARE (e.g. physical and mental health needs)		e. FINANCIAL SELF-NEGLECT (e.g. inability to manage		
c. HEALTH and SAFETY HAZARDS (e. unsafe environment)	·		n personal financ	
ABUSE RESULTED IN (v" CHECK ALL THA	T APPI Y)	i. OTTILIN		
		OSPITALIZATION	CARE PROVIDI	ER REQUIRED
DEATH MENTAL SUFFERING	SERIOUS BODILY IN			LIVINEQUINED
UNKNOWN	SEINIOUS BODIL! IIV	IJUINI OTHER (SI	LOIF 1 <u>)</u>	
GOC 341 (3/15)				PAGE 1
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F. REPORTER'S OBSERVATION STILL HAVE ACCESS TO Section "Reporting Resporting Responsible Responsibility Responsibility Responsibility Responsibility Responsibility Responsibility Responsibility Responsibility	THE VICTIM? DOES nsibilities and Tim ongoing, etc.). L	THE ALLEGATION THE Frames" within	N INVOL the Gen	VE A SEF	RIOUS BODIL' ructions)? PR	Y INJURY (see definition COVIDE ANY KNOWN T	n in
v' CHECK IF MEDICAL, FINANC	IAL (ACCOUNT INFORMA	TION, ETC.), PHOTOGR	APHS, OR	OTHER SUF	PPLEMENTAL INF	FORMATION IS ATTACHED.	
G. OTHER PERSON BELIEVE	D TO HAVE KNOWL				ers, neighbors,	medical providers, agencies	;
NAME			involved,	eic.)		RELATIONSHIP	
ADDRESS						TELEPHONE	
II FAMILY MEMBER OR OTHE	D DEDCON DECDO	NCIDLE FOR VICT	INVIC CA	DE (If		()	
H. FAMILY MEMBER OR OTHE	ER PERSON RESPO	IF CONTACT I			nown, list contac	RELATIONSHIP	
			2.100.1011				
ADDRESS		CITY			ZIP CODE	TELEPHONE	
						()	
I. TELEPHONE REPORT MAD		w Enforcement Loc f Developmental Service	al Ombud	sman C	alif. Dept. of Stat	e Hospitals	
NAME OF OFFICIAL CONTACTED BY PHONE	Odini. Dopi. o	i Developinental del viol		ELEPHONE		DATE/TIME	
			()			
J. WRITTEN REPORT Enter in Serious Bodily Injury*, please refel California Department of Social Se	r to "Reporting Respo	nsibilities and Time F					
AGENCY NAME	ADD	RESS OR FAX					
ACENOVALANE	400	DE00 0D FAV			Date Mailed	Date Faxed	
AGENCY NAME	ADD	RESS OR FAX			Date Mailed	Date Faxed	
AGENCY NAME	ADD	RESS OR FAX			Date Malieu	Bate Faxed	
					Date Mailed	Date Faxed	
K. RECEIVING AGENCY USE	ONLY Telephone	Report Written	Report				
1. Report Received by				Date/Time			
2. Assigned Immediate Re Not APS	sponse Ten-l Not Ombudsman	Day Response No Ten-Day		itial Respo	onse (NIR)		
Approved by		P	ssigned	to (option	al)		
Calif. D	Licensing & Cert.; ept. of State Hospitals ept. of Developmental	; Law Enforceme		ibudsman; Professiona	Bureau of al Licensing Boa	f Medi-Cal Fraud & Elder Al ard;	 ouse
Other (Specify)			Da	ate of Cross-Re	port	
APS/Ombudsman/Law Enforce	ement Case File Nu	mber					
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